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GOOD SAMARITAN SOCIETY - NEWELL	415 WEST HIGHWAY NEWELL, IA 50568

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F 000	INITIAL COMMENTS Correction date: _____ The following deficiencies relate to the recertification and licensure survey conducted 12/16/13, to 12/19/13. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000	See attached	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

1/21/14
P6.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on record review, interviews, and facility policy/procedures, the facility failed to investigate an allegation of abuse and report the findings to the Iowa state survey and certification agency within 24 hours of the allegation. The facility reported a census of 35 residents.

Findings included:

The Minimum Data Set (MDS) assessment tool dated 11/12/13 documented Resident #6 with intact cognition, no delirium, mild depression, and verbal and other behaviors. The MDS documented the resident's diagnoses included heart failure and diabetes.

A Psychiatric Services visit report dated 11/7/13 documented the resident's diagnoses included chronic paranoid schizophrenia, bipolar with psychotic features, generalized anxiety, personality disorder, pleural effusion, chronic obstructive asthma, emphysema, chronic heart disease, congestive heart failure, and peripheral venous insufficiency. The report directed staff to decrease the resident's Zyprexa (an antipsychotic medication) to 2.5 mg. (milligrams) twice a day

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for two weeks, decrease Risperdal (an antipsychotic) to 1 mg. three times daily for two weeks and discontinue, and administer Seroquel XR (an antipsychotic medication) 300 mg. daily at supper.

The resident's Comprehensive Care Plan dated 11/22/13 identified the resident had a problem with altered though processes, mood, and behaviors related to schizophrenia, chronic obstructive lung disease, congestive heart failure, memory and decision making deficits, unusual loud verbal outbursts, and paranoid statements. The care plan documented the resident with a history of loud verbal outbursts about sex and babies. The plans and approaches directed staff to encourage the resident to move out of areas where voices heard, psychiatric consults, remove the resident from activities when disruptive, and diversion not successful and can aggravate situations.

Interdisciplinary Progress Notes (nursing notes) documented the following:

a. On 11/1/13 at 3:10 p.m. the resident stated he/she had a baby at the facility.

b. On 11/15/13 at 3:15 p.m. the resident in the hallway and yelled that staff planned to take his/her children away.

c. An entry dated 11/18/13 at 10:00 p.m. staff requested the resident to take a bath and the resident stated the bath would kill him/her.

d. An entry dated 11/20/13 at 1:30 a.m., the resident toileted, bright red blood/urine observed in the toilet, the resident without blood near

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genitalia and rectum, and no wounds observed on the resident's buttocks and legs.

e. An entry dated 11/20/13 at 4:30 a.m. and 11:05 a.m. staff observed blood on the resident's incontinent brief and an appointment made for the resident to see the physician the same day.

f. An entry dated 11/20/13 at 3:40 p.m. the resident left with the facility van driver to physician appointment.

g. Staff F, LPN (Licensed Practical Nurse), documented an entry dated 11/20/13 at 5:25 p.m. that the resident returned to the facility, the bus driver reported that the resident stated a person of the opposite sex entered his/her room and raped him/her and the resident concerned about how the physician appointment would be paid for. The nurse documented the resident made no comments to him/her, the resident went to supper, and the resident's sibling updated.

Review of the record revealed no further documentation related to the resident's rape allegation.

The physician office visit report, dated 11/20/13, documented the resident seen for external hemorrhoids bleeding at times the previous few days. The report documented the physician completed an anal noscopy, found evidence of one small internal hemorrhoid, and prescribed treatment.

During interview 12/17/13 at 7:30 a.m., the DON (Director of Nursing), stated the bus driver reported to her right away that the resident stated he/she raped during the van trip back to the

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facility 11/20/13. The DON stated she had no documentation or investigation report related to the resident's allegation. The DON stated the resident had past history of child bearing stories while in the facility, accused a staff nurse of taking his/her children, and kept the resident away from staff and residents of the opposite sex as much as possible. The DON stated Staff F spoke to the resident about the rape allegation and the resident backed off on the allegation and the resident had an anal anoscopy that afternoon at the physician's office.

During a telephone interview 12/17/13 at 10:45 a.m., the van driver verified that after the resident saw the physician on 11?20/13 and on the way back to the facility, the resident stated a person of the opposite sex entered the room and raped him/her. The van driver told the resident he/she planned to report the allegation to the nursing department on return to the facility. The van driver stated he/she told the DON of the allegation upon return to the facility and the DON instructed him/her to inform Staff F.

During a telephone interview 12/17/13 at 11:30 a.m., Staff F stated he/she had not questioned the resident specifically about the rape allegation because the resident becomes upset and behaviors escalate with new situations. Staff F stated she believed if the rape allegation happened the resident would have reported it to her when they talked that evening.

During interview 12/18/13 at 7:20 a.m., the DON, with the Administrator present, stated she notified the physician the previous day of the resident's rape allegation on 11/20/13 after the appointment. The DON received a letter from the physician that

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documented the resident's allegation, a nurse present during the physician's examination, and the resident's diagnosis hemorrhoids. The physician's letter documented the resident had a history of emergency room visits for previous allegations with no known rape status.

During interview 12/18/13 at 10:15 a.m. Staff F stated she visited with the resident on 11/20/13 after he/she returned from the physician appointment for bleeding. Staff F verified a physical assessment not completed and physician notification of the allegation not done.

The facility Abuse/Neglect 7 Key Components, revised 4/13, directed staff to identify the staff member responsible for the initial report, investigation of alleged violations, and reporting to the proper authorities. The document directed staff to report violations and substantiated incidents to the state and other required agencies and take correction action depending on the outcome of the investigation.

The facility Abuse and Neglect policy, revised 9/13, directed staff to notify the administrator, other officials according to state law, and the state survey and certification agency of any suspected violation of mistreatment, neglect, abuse, and injuries of unknown origin. The policy documented the facility needed evidence that all alleged or suspected violations thoroughly investigated and reported to the state survey and certification agency within five working days of the incident or sooner as directed by state law.

During interview 12/19/13 at approximately 8:00 a.m., the Administrator stated he remembered the DON informed him of the resident's allegation the

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F 225	Continued From page 6 evening of 11/20/13 soon before he left for the day. The Administrator vaguely remembered saying about the incident needed looked into.	F 225		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to assure Care Plans followed for 2 of 9 residents reviewed. Concerns were identiifed with Resident #4 and #9. The facility reported a census of 35 residents. Findings included: 1. According to the Cumulative Diagnosis List Resident #9 had diagnoses that included Syncopal Episode, Alzheimer's Disease, Dementia with wandering behavior, and Degenerative Joint Disease. The resident's 10/22/13 Minimum Data Set (MDS) documented the resident had impairment of short and long term memory and severely impaired decision making ability. The resident required extensive assistance for transfers and did not ambulate. Staff documented on an Incident Report the resident fell on 7/30/13 and sustained a laceration above the right eye. Staff documented the alarm sounding. On 12/18/13 at 9:47 a.m. observation revealed	F 282		

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the resident in a wheelchair in his/her room. A cord with a clip on the end extended from the seat of the wheelchair, and draped over the back of the chair. Observation revealed the cord from the seat alarm not attached to a speaker box. The resident's 11/1/13 Care Plan lacked any direction to staff to apply an alarm.

During interview on 12/18/13 at 11:12 a.m. the Director of nursing stated the resident should have a seat pad alarm on at all times. She provided the previous (5/29/13) Care Plan which directed staff to discontinue the personal (clip type) alarm and use a pressure (seat pad) alarm at all times. She stated it had inadvertently been omitted from the current Care Plan.

During interview on 12/18/13 at 11:16 a.m. Staff K, Certified Nursing Assistant (CNA) stated the speaker box had been missing but stated the resident had one on when she got the resident out of bed that morning. She stated she didn't know where it had gone.

2. Resident #4's December 2013 Medication Administration Record (MAR) documented diagnoses including but not limited to osteoarthritis, spinal stenosis, depression and anxiety. The resident's 11/12/13 Minimum Data Set (MDS) documented the resident had severely impaired decision making ability. The resident required extensive assistance of 2 staff for transfers, did not ambulate and was at risk for pressure ulcers. The resident's Care Plan lacked direction to staff in regard to repositioning.

During observation on 12/17/13 at 10:12 a.m. the resident slept in his/her wheelchair in the facility living room. At 12:41 p.m. the resident remained

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F 282	Continued From page 8 asleep in the wheelchair in the dining room. At 1:14 p.m. the resident remained asleep in the wheelchair in the Activity Room. At 1:51 p.m. the resident remained asleep in the wheelchair near the Nurses Station. At 1:51 p.m. staff took the resident to his/her room to toilet. The resident remained in his/her wheelchair without the benifit of repositioning for 3 hours and 39 minutes. During observation on 12/18/13 at 7:06 a.m. the resident sat sleeping in his/her wheelchair in the living room. At 8:02 a.m. the resident remained asleep in the wheelchair in the dining room. At 8:26 a.m. the resident remained in the wheelchair in the dining room fed by staff. At 8:53 a.m. the resident remained in the wheelchair in the dining room being fed. At 9:48 a.m. the resident slept in the wheelchair in the dining room. At 10:04 a.m. staff took the resident to his/her room. At 10:39 a.m. the resident laid in his/her bed. Obseravtion revealed the resident without repositioning for 2 hours and 58 minutes. During interview on 12/19/13 at 8:53 a.m. the Director of Nursing stated staff are instructed at orientation that resident's who can't reposition independently are to be assisted to reposition at least every 2 hours. That is an unwritten part of the residents' Care Plans. During interview on 12/18/13 at 3:13 p.m. the DON stated repositioning had not been added to the Care Plan because "it's a given" that residents who are dependent should be repositioned at least every 2 hours.	F 282		
F 317 SS=G	483.25(e)(1) NO REDUCTION IN RDM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a	F 317		

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resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and staff interviews the facility failed to assure staff assisted residents with Functional Maintenance Programs as planned for 1 of 9 residents reviewed who had been admitted to the facility without any limitations in functional range of motion. (Resident #9) The facility reported a census of 35 residents.

The findings include:

1. The Cumulative Diagnosis List documented Resident #9 had diagnoses including but not limited to Alzheimer's Dementia and degenerative joint disease. The resident's 10/22/13 MDS documented the resident had impairment of short and long term memory and severely impaired decision making ability. The resident required assistance with transfers and did not ambulate. The Resident's 3/5/13 and 8/6/13 MDSs documented the resident had no impairment in functional range of motion. The resident's 10/22/13 MDS documented the resident had impairment in range of motion of both lower extremities.

The resident's 11/1/13 Care Plan directed staff to assist the resident with a FMP (Functional Maintenance Program) 3x/wk. (three times a

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week) for gentle passive range of motion to the upper and lower extremities.
On 5/29/13, staff documented in the Interdisciplinary Assessments and Summary Reviews the resident continued with a functional maintenance program which was appropriate. On 10/29/13 staff documented the resident continued with FMP and the resident was unable to bend his/her knees.

Staff documented in the Restorative Plans/Approaches flow sheets assistance provided as follows:
In December 2012 staff assisted the resident with the exercises 12 times
In January 2013 staff assisted the resident with the exercises 14 times and documented one refusal.
In February 2013 staff assisted the resident with the exercises 13 times.
In March 2013 staff assisted the resident with the exercises 11 times and documented twice rehab unavailable.
In April 2013 staff assisted the resident with the exercises 13 times.
In May 2013 staff assisted the resident with the exercises 15 times.
In June 2013 staff assisted the resident with the exercises 12 times.
In July 2013 staff assisted the resident with the exercises 14 times.
In August 2013 staff assisted the resident with the exercises only 3 times.
In September 2013 staff assisted the resident with the exercises only 5 times. On 9/5/13 staff documented in the Documentation Notes the resident had minimal range (ability) to flex his/her knees with the range of motion program. The record lacked documentation prior to this

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indicating the resident had limitations in range of motion to the knees.

In October 2013 staff assisted the resident with the exercises 10 times. On 10/7/13 staff documented in the Documentation Notes the resident's knees are stiff and his/her ability to flex them during range of motion is minimal. On 10/14/13 staff wrote the resident's shoulder abduction/adduction was poor and he/she seemed to not be able to relax. Also, his/her knee flexion was poor. Staff G documented she couldn't bend his/her knees at all.

In November 2013 staff assisted the resident with the exercises 9 times.

By December 18, 2013 staff had assisted the resident with the exercises only one time.

During observation on 12/19/13 at 9:12 a.m. Staff G, Certified Nursing Assistant, Restorative Aide assisted the resident with Range of Motion exercises and demonstrated the resident could not bend the knees nor fully straighten them.

During interview on 12/17/13 at 9:58 a.m. the Director of Nursing stated the Restorative Aide had been on vacation since 12/7/13 and she had no one else to do the Restorative programs. She stated the facility did not do any assessment/measurement of resident range of motion to determine the effectiveness of functional maintenance programs. At 12:56 p.m. the DON provided the August schedule for the Restorative Aide and confirmed she had been scheduled to do restorative treatments only 7 days that month. The DON agreed residents scheduled for 3x/week would amount to 12x/month which couldn't possibly be accomplished with the Restorative Aide scheduled only 7 days.

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F 317	Continued From page 12 During interview on 12/18/13 at 2:54 p.m. the Administrator stated in August they had lost 3-4 full time staff and several students went back to school and that was why the Restorative programs were not being done as planned. During interview on 12/19/13 at 9:12 a.m. Staff G, Restorative Aide, stated she couldn't complete the residents' exercise programs as planned because she had not been scheduled enough days to get them done. During interview on 12/17/13 at 12:49 p.m. when asked if the facility did any Quality Assurance reviews to assure residents received their exercise programs as planned the DON replied, "There will be now."	F 317		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with staff the facility failed to assure Functional Maintenance Programs provided as planned for residents admitted with limitations in range of motion (Resident #1, #4, #5, #7, #8). The facility reported a census of 35 residents.	F 318		

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The findings include:

1. According to the Cumulative Diagnosis List, Resident #1 had diagnoses that included Alzheimer's Dementia and osteoporosis. The MDS with a reference date of 11/19/13, identified the resident had short and long term memory impairment and severely impaired decision making ability. The resident required extensive assistance of two staff for transfers and did not ambulate. A 10/28/13 Occupational Plan of Care documented the resident's left hand severely contracted. The resident's 12/5/13 Care Plan identified the resident had impaired physical mobility related to a history of bilateral hip fractures and left wrist fracture. The Care Plan directed staff to provide a functional maintenance program 3x/wk. [3 times per week] for passive range of motion to the upper and lower extremities.
During observation on 12/16/13 at 2:02 p.m. the resident sat in a chair in his/her room. The resident had a piece of gauze between the left thumb and first finger. The thumb appeared to be contracted toward the palm of the resident's hand.

On 7/1/13, staff documented in the Interdisciplinary Assessments and Summary Reviews the resident continued with a functional maintenance program 3x/wk., the program was appropriate and the resident cooperative. On 9/18/13 staff documented the resident continued with a functional maintenance program which remained appropriate. On 11/24/13 staff documented the resident continued with a functional maintenance program.

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Staff documented on the Restorative Plans/Approaches flow sheet that staff assisted the resident with the exercises 3 times in August 2013. Staff assisted the resident with the exercises 5 times with one refusal documented in September 2013. Staff assisted the resident with the exercises 8 times in October 2013. Staff documented the resident somewhat resistant at times. Staff assisted the resident with the exercises 9 times in November 2013 and documented the resident resistive at times. On December 18, 2013 staff had assisted the resident with the exercises only twice.

During an interview on 12/17/13 at 9:58 a.m. the Director of Nursing stated the resident ' s hand splint had been discontinued due to pressure on the hand. The Director of Nursing stated staff administered Tylenol to the resident prior to the exercises to minimize any discomfort with the exercises. Review of restorative participation and PRN medication administration sheets revealed the following:
In August 2013 staff documented once the resident had refused his/her medications. The record lacked documentation which indicated staff administered Tylenol in conjunction with any of the other days staff assisted with the exercises.
In September 2013 staff documented Tylenol administered on 2 of the 6 days staff assisted the resident with the exercises.
In October 2013 staff administered Tylenol 1 of the 8 days staff assisted the resident with the exercises.
In November 2013 staff administered Tylenol on 5 of the 9 days staff assisted the resident with the exercises.
In December 2013 staff documented 1 of 2 days staff assisted the resident with exercises the

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F 318	Continued From page 15 resident had refused his/her medicatiDn. During an interview on 12/17/13 at 9:58 a.m. the DirectDr Df Nursing repDrted the Restorative Aide to be on vacation since 12/7/13 and she had no one else to do the Restorative programs. She stated the facility did not do any assessment/measurement of resident range of mDtion to determine the effectiveness of functional maintenance prDgrams. At 12:56 p.m. the DON provided the August schedule for the RestDrative Aide and cDnfirmed she had been scheduled tD dD restDrative treatments only 7 days that month. The DON agreed residents scheduled for 3 times per week would amount tD 12 times per month which couldn't possibly be accomplished with the Restorative Aide scheduled only 7 days. During an interview on 12/18/13 at 2:54 p.m. the Administrator stated in August they had lost 3 to 4 full time staff and several students that went back to school and this was why the restorative programs were not being done as planned. During an interview Dn 12/19/13 at 9:12 a.m. Staff G, Restorative Aide, stated she couldn't complete the residents' exercise programs as planned because she had nDt been scheduled enDugh days tD get them done. During an interview on 12/17/13 at 12:49 p.m. when asked if the facility did any Quality Assurance reviews tD assure residents received their exercise programs as planned, the DON replied, "There will be nDw." 2. Resident #4's December 2013 MedicatiDn Administration Record (MAR) documented	F 318		

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diagnoses including but not limited to osteoarthritis and spinal stenosis. The resident's 11/12/13 Minimum Data Set (MDS) documented the resident had impairment of short and long term memory and severely impaired decision making ability. The resident required extensive assistance of two staff for transfers and did not ambulate.

The resident's 11/22/13 Care Plan directed staff to assist the resident with a Functional Maintenance Program (FMP) three times per week for Active Assisted Range of Motion to the Upper and Lower extremities.

Staff documented on a 6/17/14 Interdisciplinary Assessment and Summary Review the resident "Is on a functional maintenance program - program is appropriate et resident does cooperate." On 9/3/13 staff wrote, "Is on a functional maintenance program; program appropriate." On 11/14/13 staff documented, "Continues with FMP 3x/wk. [3 times a week]. Resident participates."

On the resident's Restorative Plans/Approaches flow sheet staff documented in August 2013 staff assisted the resident with the exercises only three times. In September 2013, staff assisted the resident with the exercises only 5 times. In October 2013 staff assisted the resident with the exercises 8 times. In November 2013 staff assisted the resident with the exercises 9 times. On December 18, 2013 staff had assisted the resident with the exercises only two times. Staff documented at times the resident resisted exercises to the right upper extremity, but lacked documentation indicating the resident refused participation outright.

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3. Resident #7's Cumulative Diagnosis List documented diagnoses including but not limited to a hemorrhagic stroke in March 2012, osteoarthritis and an intracranial hemorrhage (bleeding in brain) on 3/5/13 resulting in right hemiparesis (paralysis). The resident's 10/29/13 MDS documented the resident had no impairment of cognitive function, required assistance with transfers and ambulation and had functional limitations in range of motion of one upper extremity and one lower extremity.

The resident's 11/8/13 Care Plan directed staff to assist the resident with a Functional Maintenance Program 3x/wk. [three times a week]. The program consisted of standing exercises in parallel bars; using 1# [pound] ankle weights, heel and toe raises; alternation hip abduction; alternation hip extension; mini squats; marching; side stepping; backwards walking and Nustep [exercise machine].

Staff documented on an 11/5/13 Interdisciplinary Assessment and Summary Review the resident continues with FMP.

On the resident's Restorative Plans/Approaches flow sheet staff documented in August 2013 staff assisted with the exercise program only 3 times. In September, staff assisted with the exercises 5 times. In October, staff assisted with the exercises 11 times. In November, staff assisted with the exercises ten times. On December 18, 2013, staff had assisted the resident with the exercises only 3 times.

The record lacked any documentation reflecting the resident had declined to participate in the

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exercises.
During an interview on 12/18/13 at 1:47 p.m. the resident confirmed he/she had not had the exercises for a while and thought the staff that assisted with them had went to school.

4. The MDS assessment tools dated 2/19/13 and 4/30/13 documented Resident #5 with moderately impaired cognition, required extensive assistance of one staff physical assistance to walk in the room and corridor, not steady and required assistance of one staff to balance during transitions and walking, without range of motion impairment, and used a walker and wheel chair for mobility. The MDS documented the resident's diagnoses included non-Alzheimer's dementia, depression, and osteoporosis.

The MDS assessment tool dated 7/16/13 documented Resident #5 with moderately impaired cognition, had not walked in the room and hall, balance remained the same, no longer used a walker for mobility, used a wheel chair for mobility, and remained without range of motion impairment.

The MDS assessment tool dated 10/8/13 documented resident #5 with moderately impaired cognition, required extensive assistance of two to walk in the corridor, had not walked in the room, required assistance of one staff to balance during transitions and walking, used a wheel chair for mobility, and remained without range of motion impairment.

The resident's 11/30/12 Comprehensive Care Plan documented the resident had a self- care deficit with activities of daily living and potential for injury due to falls related to history of falls. The

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plans and approaches included to ambulate the resident one time daily with a forward wheeled walker and gait belt with a wheel chair pulled behind the resident, distance as tolerated, and the resident independent with wheel chair mobility. The resident's 3/1/13 Comprehensive Care Plan documented the plans and approaches for ambulation with a walker and gait belt discontinued 3/22/13. An intervention dated 5/1/13 directed staff to ambulate the resident with a walker per resident request.

The resident's 10/18/13 Comprehensive Care Plan documented the resident no longer used a walker, staff to assist with transfers, and the resident non- compliant at times and independently transferred self.

Record review revealed a Physical Therapy (PT) Evaluation and Plan of Treatment documented the resident received services from 7/6/12 to 8/3/12 after a right pubic ramus fracture and decreased gait ability. The Therapy Daily/Weekly Documentation sheet dated 8/2/12 documented the resident walked 46 feet, 54 feet, and 78 feet.

A Therapy Documentation Notes sheet dated 8/2/12 recommended the resident receive a functional maintenance program for ambulation with a front wheel walker, distance as tolerated, one person assist, and follow with a wheel chair.

Restorative Plans/Approaches sheets directed staff to ambulate the resident once daily with a front wheeled walker, gait belt, distance as tolerated and follow with a wheel chair. The sheets documented the resident received the functional maintenance plan as follows:

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a. During December 2012 staff assisted the resident with ambulation 18 to 60 feet (ft.) 18 out of 31 days, refused one day, and ambulated from one to three minutes.
b. During January 2013 staff assisted the resident with ambulation 15 to 72 ft. 25 out of 31 days, no refusals documented, ambulated from one to four minutes, and the resident not asked one day.

c. During February 2013 staff assisted the resident with ambulation 15 to 67 ft. 19 of 28 days, no refusals documented, ambulated one to two minutes, and the resident not asked one day due to influenza.

d. The March 2013 restorative sheet requested and not found by facility staff.

A 3/22/13 at 12:00 p.m. Interdisciplinary Progress Notes sheet (nursing notes) documented the resident's ambulation program discontinued due to increased resident agitation when walked. The notes dated 1/5/13 to 3/22/13 lacked documentation the resident had increased agitation when walked.

During an interview on 12/17/13 at 11:15 a.m., Staff L, CNA (Certified Nurse's Aide) stated the resident no longer walked.

During an interview on 12/17/13 at 12:15 p.m., Staff D, CNA, stated the resident no longer walked.

During an interview on 12/18/13 at 7:30 a.m., the DON (Director of Nursing) stated the resident without a walking program since March 2013, needed to talk to Staff F, LPN (Licensed Practical Nurse), to find out why the program discontinued,

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and a range of motion program not started because the resident able to move own arms and legs when sat in recliner.

During an interview 12/18/13 at 10:10 a.m., Staff F stated the resident's functional maintenance stopped in March 2013 because the resident no longer wanted to walk and yelled out to stop walking. Staff F stated sometime after that time, staff attempted to walk the resident, the resident remembered why he/she no longer wanted to walk, and said to stop. Staff F stated the resident had good range of motion, moved extremities well.

During an interview 12/18/13 at approximately 1:00 p.m., the MDS Coordinator stated she checked nursing documentation and talked to staff before coding a resident's ambulation status on the MDS. The MDS Coordinator stated the resident needed to walk three times during the seven day assessment period to document a three (resident walked with extensive staff assistance) instead of an eight (resident had not walked).

During an interview 12/18/13 at 1:52 p.m., the MDS Coordinator stated talked to a night nurse and that nurse ambulated the resident to the bathroom about a month ago.

5. The MDS assessment tool dated 11/11/13 documented Resident #8 with intact cognition, independent with ambulation in the room and corridor, and required limited staff assistance when toileted.

An Occupational Therapist Therapy Daily/PRN (as needed) Documentation Notes sheet dated

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F 318	Continued From page 22 11/20/13 directed staff to provide the resident with a restorative nursing program beginning 11/25/13. The program included bilateral upper extremity exercises with a one pound cuff weight. The November 2013 Restorative Nursing Program sheet (sheet not dated) documented the resident had the program one time the week of Monday, 11/25/13. The December 2013 sheet documented the resident received the program two times the week of 12/1/13 to 12/7/13 and had not received the program this month after 12/6/13. A Physical Therapist Therapy Daily/PRN Documentation Notes sheet dated 11/21/13 directed staff to provide a maintenance therapy program with the Nu-Step three times weekly for 10 to 15 minutes as the resident tolerated. The November 2013 Restorative Nursing Program sheet (sheet not dated) documented the resident had not used the Nu-Step and refused the Nu-Step one time because had company. The December 2013 Restorative Nursing Program sheet documented the resident used the Nu-Step three times the week of 12/1/13 to 12/7/13 and had not used the Nu-Step since 12/6/13. During an interview 12/17/13 at 8:20 a.m., the DON verified restorative/functional maintenance programs not completed since the restorative CNA left for vacation on 12/6/13 and remained on vacation this week. The DON stated no staff available to provide residents their program.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 23 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure Care Plan interventions followed for 1 of 3 residents reviewed with a history of falls to prevent falls (Resident #4). The facility reported a census of 35 residents. Findings included: Resident #4's Cumulative Diagnosis List documented diagnoses including but not limited to Alzheimer's dementia and Degenerative Joint Disease. The resident's 11/12/13 Minimum Data Set (MDS) documented the resident had impairment of short and long term memory and severely impaired decision making ability. The resident further required extensive assistance of staff for transfers and did not ambulate. Staff documented on Incident Reports the resident had a history of falls on 1/6/13; 1/18/13; 4/14/13; 5/30/13; 7/4/13; 7/26/13 and 8/24/13. On 8/24/13 at 11:20 p.m. staff documented on an Incident Report staff found the resident on the floor on his/her right side. The resident stated it hurts all over. The resident's used a personal (clip type) alarm and a pressure/pad alarm. The pad alarm sounded but the personal alarm did not. Staff documented a plan to place the	F 323		

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F 323	Continued From page 24 personal alarm speaker box on the far side of the bed so the alarm would disengage if the resident got up. On 11/13/13 at 9:00 p.m. staff found the resident on the floor. The resident had a bruise 5 x 4 centimeters on the forehead and another 3.5 x 2.5 cm. on the left side of the head. The personal alarm remained attached and had not sounded. Neither had the pad alarm. Staff documented a plan to put the personal alarm on the far side of the bed. The resident's 9/6/13 Care Plan, in use at the time of the fall, lacked any direction to staff to place the personal alarm on the far side of the bed until a hand written entry dated 11/13/13. A written statement from the Director of Nursing documented staff had failed to place the pressure pad alarm on the bed. During interview on 12/17/13 at 10:44 a.m. the Director of Nursing confirmed the intervention to place the personal alarm box on the far side of the bed had not been added to the Care Plan after the 8/24/13 fall. She didn't know why and confirmed at the time of the fall on 11/13/13 the alarm box had not been on the far side of the bed.	F 323		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		

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F 363	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to serve 8 residents on a diet with ground meat the portion size in accordance with the planned menu for one meal. The facility identified a census of 35 residents. Findings included: The Week 1 Monday Noon Meal menu on 12/16/13 for residents with a pureed diet order included: 1 piece ground cornflake baked chicken During interview 11:07 a.m. Staff C (cook) stated she planned to grind cornflake baked chicken for 12 residents on a ground diet. During observation, Staff C placed 6 cornflake baked chicken breasts into a Robot Coupe, ground the chicken, poured the chicken into a stainless steel pan without measurement of the total volume, and placed the chicken in the steam table. During interview 12/18/13 at 12:05 p.m. the Dietary Supervisor stated each resident with a ground meat diet received a #10 scoop to equal 3 ounces of ground chicken and believed each chicken breast weighed 3 ounces. During observation of the noon meal service that began at 12:05 p.m., Staff C served 8 residents one #10 scoop of ground chicken. After serving completed at 12:30 p.m., Staff C measured the remainder of the ground chicken and stated one #10 scoop left over. During interview 12/18/13 at 12:30 p.m., the	F 363		

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F 363	Continued From page 26 Dietary Supervisor stated 8 residents received a ground meat diet. Staff C stated the residents with a ground meat diet always received a #10 scoop of meat to equal 3 ounces. The Dietary Supervisor and Consultant Dietician verified the menu directed staff to serve each resident one piece of ground cornflake chicken and the 8 residents failed to receive enough chicken at the noon meal. The Dietary Supervisor checked the package of chicken and stated each piece weighed 4 ounces. The Consultant Dietician verified staff needed to serve each resident with ground meat diet orders one piece of chicken according to the planned menu.	F 363		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by:	F 368		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - NEWELL	415 WEST HIGHWAY NEWELL, IA 50568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 368	Continued From page 27	F 368		

Based on resident and staff interview the facility failed to offer snacks at bedtime daily. The facility reported a census of 35 residents.

Findings include:

1. During confidential group interview on 12/17/13 at 1:30 p.m., with 8 resident the facility identified as interviewable 6 of 8 residents stated staff failed to offer snacks after supper. One of the 6 residents stated he/she asked for a sandwich sometime between 12:00 a.m. and 2:00 a.m. and staff get a sandwich from the kitchen. Several residents stated staff do not bring the snack cart around after supper. One resident stated he/she asked for snacks and staff never returned.

During interview 12/18/13 at 2:45 p.m. Staff A, CNA (Certified Nurse's Aide), stated she worked 4 to 5 evenings a week and residents offered a snack from a snack cart between 2:30 and 4:00 p.m. Staff A stated when she observed a resident eat supper poorly, she offered ice cream, pudding, or something else the resident liked to eat. Staff A stated the snack cart placed by the nurse's station after supper, the nurse gets the cart when the CNA's too busy, and most residents offered a snack after supper if the CNA's not too busy.

During interview 12/18/13 at 2:55 p.m. the Administrator and (DON) Director of Nursing stated they believed bed time snacks offered to residents because they saw the snack cart out when they remained at work after supper.

During interview 12/18/13 at 4:10 p.m., Staff B, CNA, stated she worked 5 evenings a week at the facility and worked at the facility for 1 month.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	12/19/2013

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F 368	Continued From page 28 Staff B stated the snack cart not available for residents after supper since she began employment. Staff B stated snacks passed to residents when requested after supper. During interview 12/19/13 at 8:35 a.m., Staff J, RN (Registered Nurse), stated he worked an average of 4 evenings per week, evening shift very hectic lately due to new admissions, 3 CNA's worked the shift and 1 staff left at 8:00 p.m., medications and treatments come first, and he passed snacks to the usual 9 to 10 residents that want snacks between 7:30 p.m. and 8:00 p.m. Staff J stated some residents in bed asleep when snacks passed, at times work is very hectic and snacks don't get passed, every once in awhile he passed the snack cart, and most likely not all residents asked if they wanted a snack. Staff J stated the CNA's busy and had no time to pass snacks in the last month.	F 368		

Lucas State Office Building, 3212 East 12th Street, Des Moines, Iowa 50319-0083 Health Facilities

To: Peggy Gilmore, Program Coordinator

Plan of Correction:
Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual.

F225 481—58.43(135C) Resident abuse prohibited

1. On 12/17/13, the Director of Nurses Services spoke with staff F on the phone regarding the need to complete and incident report and inform administration of any allegations of abuse and neglect so self reporting to DIA can be completed.
2. All residents could be affected.
3. All nursing staff were re-educated by the Director of Nurses Services on 1/21/14 regarding the centers Abuse and Neglect policy and procedure and the self reporting requirements to DIA. All department head were re-educated by the Administrator on January 21, 2014 regarding the above.
4. Audits monitoring alleged reports of abuse and neglect by residents will be done on 10 random staff by the Director of Nurses Services/Director of Nurses Services designee weekly x4, bi-weekly x2, monthly x3 then taken to the Quality Assurance meeting for further recommendations.
5. Completion date 1/21/14

F282 481—58.20(135C) Duties of health service supervisor

1. On 12/18/13, the Director of Nurses Services re-educated staff K regarding resident #9 care planned alarm usage and the alarm box needing to be checked that it is intact. Also, on 12/18/13, the Director of Nurses Services reviewed the system where the care plan coordinator gets the new interventions to be entered on the new care plans. On 12/18/13, the Director of Nurses Services re-educated staff E & D regarding the need to reposition dependent residents who can not on there on every 2 hours.
2. All residents with a care planned intervention of alarm use and who are dependent on staff for repositioning could be affected. The Director of Nurses Services reviewed all care plans confirming those residents with alarms usage and dependent on staff for repositioning for appropriateness of 1/16/14.
3. All nursing staff was re-educated regarding following the residents care plans regarding alarm usage, physically checking the alarms each day to make sure they are intact, and repositioning all dependent residents who can't reposition themselves every 2 hours on 1/21/14 by the Director of Nurses Services.
4. Audits monitoring placement of pressure alarms of 5 random residents and repositioning of 5 random dependent residents every 2 hours per the resident care plan will be done by the Director of Nurses Services/Director of Nurses Services designee weekly x4, bi-weekly x2, monthly x3 then taken to the Quality Assurance meeting for further recommendations.
5. Completion date: 1/21/14

F317 481—58.19(135C) Required nursing services for residents

1. On 12/17/13, the Director of Nurses Services reviewed the restorative aides schedule to confirm staff availability to complete programs the following week and thereafter according to the residents care plans.
2. All residents receiving restorative and/or functional maintenance programs could be affected. On 1/16/14 all residents care plans were reviewed for appropriateness of programs and documentation reviewed for completeness by the restorative aides.
3. The Director of Nurses Services spoke with the restorative aides on 12/18/13 & 12/19/13 regarding the necessity of completing the residents programs according to their care plan.
4. Audits monitoring the completeness of all restorative and/or functional maintenance programs will be done by the Director of Nurses Services/Director of Nurses Services designee weekly x4, bi-weekly x2, monthly x3 then taken to the Quality Assurance meeting for further recommendations.
5. Completion date: 12/19/13

F318 481—58.20(135C) Duties of health service supervisor

1. The Director of Nurses Services reviewed residents 1, 4, 5, 7, & 8 care plans for appropriateness of functional maintenance programs and restorative aide documentation for completeness on 1/16/14.
2. All residents receiving restorative and/or functional maintenance programs could be affected. On 1/16/14 all residents care plans were reviewed for appropriateness of programs and documentation reviewed for completeness by the restorative aides.
3. The Director of Nurses Services spoke with the restorative aides on 12/18/13 & 12/19/13 regarding the necessity of completing the residents programs according to their care plan. Also, all nursing staff were re-educated about this on 1/21/14 by the Director of Nurses Services.
4. Audits monitoring the completeness of all restorative and/or functional maintenance programs will be done by the Director of Nurses Services/Director of Nurses Services designee weekly x4, bi-weekly x2, monthly x3 then taken to the Quality Assurance meeting for further recommendations.
5. Completion date: 1/21/14

F323 58.28(3) Resident safety.

1. On 1/16/14, the Director of Nurses Services talked to the RN staff member who worked the night shift of 8/24/13 and completed the fall incident report of resident #4 regarding the need to write the intervention from the fall on the residents care plan. Also, the aide and nurse working on 11/15/13 at the time of that fall were given counseling and corrective action by the Director of Nurses for not following the care plan of alarm usage.
2. All residents with care planned alarms could be affected and all care plans were reviewed by the Director of Nurses Services on 1/16/14 for appropriateness of alarm usage.
3. All nursing staff were re-educated on 1/21/14 by the Director of Nurses Services regarding following the residents care plan of alarm usage.
4. Audits monitoring placement of pressure alarms of 5 random residents per the resident care plan will be done by the Director of Nurses Services/Director of Nurses Services designee weekly x4, bi-weekly x2, monthly x3 then taken to the Quality Assurance meeting for further recommendations.
5. Completion Date: 1/21/14

F363 58.24(3) Nutrition and menu planning.

1. Ground meat policy and procedure has been written and added to the dietary policy and procedure manual
2. Certified Dietary Manager will train each cook on the revised procedure
3. Each cook will demonstrate the ability to grind and service food according to the revised procedure
4. Audits of the preparation and service of ground meat will be completed one time per week for 1 month. After that time, audits will be completed one time per month for a quarter.
5. Completion date: 1/21/14

F368 58.24(3) Nutrition and menu planning.

1. On 12/18/13, the Director of Nurses Services spoke to the charge nurse Staff J and the certified nurses assistants staff A & B re-educating them on the necessity to pass and offer HS snacks to all residents.
2. All residents could be affected.
3. All nursing staff were re-educated regarding the need to pass, offer, and document HS snacks to all residents on 1/21/14 by the Director of Nurses Services.
4. Audits monitoring documentation of and watching the passing of HS snacks by the Director of Nurses Services/Director of Nurses Services designee will be done weekly x4, bi-weekly x2, monthly x3 then taken to the Quality Assurance meeting for further recommendations.
5. Completion date: 1/21/14